



## Developmental Disabilities Nurses of New Hampshire

[www.dhhs.nh.gov/dcbcs/bds/nurses](http://www.dhhs.nh.gov/dcbcs/bds/nurses)

[DDNNH@dhhs.state.nh.us](mailto:DDNNH@dhhs.state.nh.us)

### Minutes

**January 19, 2016**

1. **Mass Tex Imaging presentation** – dysphagia/swallowing disorder presentation – overview, experiential, video clips. Opportunity to tour an actual mobile unit van at the end of the presentation time. One reason to consider MBSS vs hospital based modified barium swallow study – the hospital study does not look at the esophagus while MBSS does. Mass Tex experience – in a review of 10,000 studies performed – found 36% have silent aspiration; 46% have an esophageal issue which would be unseen/not diagnosed in hospital setting.
2. **Meeting was called to order with 23 in attendance**
3. **Review** and approval of December 2015 minutes as written.
  - a) **Officers Reports-**  
**Treasurer's Report:** Read and accepted. Rivier scholarship \$250 – motion passed to send that amount again this year. Discussion about membership numbers, what do we use our dues for ensued. Debi Ellis-Nailor will follow up with future scholarship possibility of funds given being identified (labeled) as DDNNH provided and report back to the group.
3. **Business Discussion:**
  - a. November homework – Youtube videos of med administration – a couple of people looked and couldn't find anything that satisfied the need. Request to keep on the agenda. Janet, Penny, Wayne, Debi, Cheryl and Martha volunteered to be part of a subcommittee workgroup – to meet outside of the DDNNH meeting time.
  - b. Cheryl will ask about scheduling ATECH tour – possibly for April meeting.
  - c. HRST question raised by member – item i – chemical restraint – is this about aggression? Anxiety? Related to behavior plans? Discussion was wide ranging – reminder to group that HRST is a national tool – the item name does not necessarily reflect the NH practice reality. The expanded scoring descriptors may be helpful. If your individual case/question does not seem to be answered, consider sending a help ticket to the clinical director.
  - d. HRST monthly data tracker – need to be sent in monthly with progress notes.
  - e. HSI discussion – Cheryl – HRST is now in He-M 503 regulation – which is available online. The focus of our discussion was on how do we operationalize. Reminder - the intent of HSI/HRST monthly data tracker – to help advocate for health knowledge and sharing of observations and changes for the individual receiving services.
  - f. FAQ HSI discussion – decision postponed.
  - g. How do we change focus from the form used to the point/quality of care? Electronic medical record was one suggestion. EMR would be one form/one place. How we work in NH – there are pieces of information everywhere – keeping it up to date with changes is challenging at best.
  - h. We had our first 50/50 raffle today. We also raffled off the donated beautiful handmade quilted hanging from Ruth – thank you again Ruth!

**Next Meeting will be February 16, 2016**

**Submitted by:**  
**Jennifer Boisvert, RN**  
**Secretary, DDNNH**



## MINUTES

February 16, 2016

1. Meeting was called to order with 17 in attendance
2. Review and approval of January 2016 minutes – Accepted as written
3. Officer's Reports:
  - a. Treasurer's Report – Read and accepted
4. Business Discussions:
  - a. General reminder to the group that Peter is scheduled to join us next month. Jen will send out a reminder to the group to send questions (with specific regulation citations as applicable) to Peter prior to the meeting.
  - b. A couple of questions were raised about other members' experience with length of some surveyor visits and the types of concerns being noted. One specific question raised was about verbal orders – a copy of the order in question will be brought to a future meeting as it sounded to the members present as if perhaps the questioned order was actually not a true verbal order, rather a different version of an electronically signed order.
  - c. A question was raised about QA frequency – if a QA is not done within exact 6 months (to the day), then a citation could happen? The surveyor reportedly referenced the FAQs, although the specifics were not available at the meeting. A review of the FAQs did not provide specific information to address this. Cheryl requested that a copy of the surveyor communication be sent to her. Discussion ensued around using the same language as has been used for the medication administration certification period. (regulation citation inserted during creation of draft minutes: Providers shall be re-authorized to administer medications at least annually or by the last day of the 12th month from the date of the prior authorization.)
  - d. Compassionate Care Lunch n Learn (to review NH Medicaid changes related to hospice care) – needs to be rescheduled – group agreed that April would be next month available. If scheduled, meeting time will be extended to noon to accommodate.
  - e. Tour of ATECH – to be scheduled – Cheryl will ask Dennis if either May or June would work with his schedule.
  - f. November homework – Janet – transcription of current video is available in eStudio (in projects in process folder). Anyone interested in reviewing and offering suggestions is welcome to participate directly in subcommittee meetings or to send comments to Janet. Most of the identified members were unable to attend today's meeting due to the weather. Cheryl will send out a meeting request with time/date suggestions to the subgroup.

- g. HSI/HRST monthly data tracker (MDT) – Cheryl had several areas to start process of seeking input.
  - i. An algorithm for determining medical fragility has been proposed as useful – using the current HRST scoring items – please review with your specific knowledge – what item(s) capture information that you currently use in your assessment. What items could be used collectively to trigger an RN consideration of medical fragility. We know that the HCL number alone does not correlate directly to medical fragility as not everyone who has an HCL 6 is medically fragile. It is also true that an individual who is scored HCL 1 could be medically fragile. Cheryl provided handouts of the MDT, a HRST definition of medical fragility (just to have a framework reference – we are not looking to change NH’s working definition of medical fragility). Cheryl reminded the group to not only toggle yes on About Me page for medical fragile status, but to include specific notes in the HSI medical fragile comment box – a comment box to go with the medical fragile toggle is being discussed/developed.
  - ii. Additionally Cheryl requested that NTs review the HSI form – which topics/questions are not captured at all within the HRST items. Rather than lose that information, there is a proposal to change the HSI form to only include those items. Please send Cheryl your comments from this review.
  - iii. Cheryl has queried the HRST system – there are currently 4,050 records in HRST from NH, of those 7% have diabetes (national average is 9%). Cheryl also queried the number of psychotropic meds – she passed around the resulting graph. A small group of individuals have 10 psychotropic meds.
  - iv. PLEASE send in tickets to HRST as you are using the system and notice any anomalies or errors. (Don’t assume that it is already known about.)
  - v. At some point in the future, ISAs will be included in HRST so that everyone with access can see them.
- h. Kenda mentioned that she had recently participated in a PPN and CSNI work group – and wondered if the information gathered had been shared with Cheryl (specifically around ideas/comments generated regarding medical info). Cheryl did not know about this. Kenda will contact the group facilitator to request a connection be made.
- i. HRST MDT form – weight/BMI monthly box – members of the group commented that we don’t necessarily have monthly weights for everyone. For some individuals, their weight is not an issue. For other individuals their weight is an issue and they have a barrier to obtaining accurate weights with any routine frequency. Recommendation – document weights whenever they are available – be aware of that frequency and work with the team to develop awareness and resources if increased frequency is needed.
- j. About Me page – Cheryl mentioned that there is a section (with vision etc) that nurses don’t have access to make changes. If there is a need to change this, please let Cheryl know. No one present at the meeting needed access.
- k. TD risk flagged meds in HRST database – be aware that the list that HRST bought from drugs.com flags some meds that are not usually considered a TD risk. Also, HRST cannot discriminate between a regularly scheduled dose and a rare, occasional use for TD risk – both instances are flagged the same. Ticket has been sent to HRST clinical assist. There are 24 meds on the HRST database that are listed both as having TD risk and not – depending on which is selected. Some members spoke about concern for signing off a clinical review of a HRST record that has item J scored a 4 for TD risk with a med that essentially does not have a TD risk. One member said that her practice has been to input a comment on that item (in the permanent comment box) with which specific drug triggered the rating.
- l. The group present was asked if it would be useful to have a projection of HRST screens at a future meeting (to assist with understanding which page/area we are talking about) – there were many who said yes. Cheryl will bring a laptop to the next meeting with a small sample of test individuals. Not all of the screens will be functional.

**Next Meeting will be March 15, 2016**

**Submitted by:  
Jennifer Boisvert, RN  
Secretary, DDNNH**



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### MINUTES

March 15, 2016

- 1) Meeting was called to order with 34 in attendance
- 2) Review and approval of February minutes as written
- 3) Officers Reports :
  - a) Treasurer's Report – accepted as written
  - b) DDNA Liaison – Debi, Eileen, Pam, Wayne and Luanne are going to DDNA conference. Debi called Rivier College re: scholarship money – what our group donate goes into a pool of money for the Faye-Martinez Foundation and is disbursed to a nontraditional nursing student. Another future option for us to consider would be for DDNNH to pay for one of our DDNNH members to become a CDDN. Debi reminded us that she is looking for members of our group to write about what brought you to DD nursing as she plans to write an article for the spring DDNA newsletter (send directly to Debi's email)
- 4) Business Discussion
  - a) Reminder of upcoming guests for April and May meetings.
  - b) Cheryl spoke of mentoring for new nurse trainers – if you are willing to be a mentor, then let Cheryl know.
  - c) HRST – HSI (if it remains, it will need a new name) homework – only one person sent suggestions to Cheryl prior to the meeting. Changing the language in He-M 1201 is started – however, because the rule is due in 2018, there won't be an official change until then.
  - d) Peter and Kiki joined us for our ongoing collaborative discussions. Questions that had been sent in were discussed first.
    - i) Medical marijuana use – thoughts on how this will be managed? Discussion comments included: learn as we go, can look at the State statute (RSA 126x), how to prescribe – practitioners unsure how to prescribe, medical marijuana comes in different forms – not all are equivalent in effectiveness – oral (marinol) doesn't work well with treating spasms. One person has a medical card already – dispensary will determine the form, not the provider; a couple of individuals or their families have expressed interest. It will be treated as a scheduled (controlled) drug. Consideration must be given to a plan for managing the smoked form (re: others in the home)
    - ii) HRST vs HSI – specifically – are the surveyors going to be looking for the HRST to be reviewed prior to annual health assessment (physical) and non emergent medical appointments – at this point the surveyors are just looking to see that HRST is there and information is being documented on it. At the end of the discussion – BHF will not expect HRST monthly data tracker to be reviewed prior to annual health assessments and medical appointments. The HRST MDT will still need to be reviewed by the nurse within 30 days of initiating a program and annually thereafter.
    - iii) HSI 2015 – should the completed forms be left in for the surveyors or taken out – answer: leave in. HSI is not needed to be processed in 2016.

- iv) HRST MDT form – don't double document information. CPS (day) and residential programs (services not provided by the same person) need to have separate HRST MDT forms. However, what happens at CPS should not be documented again on the residential form. How to know when to use 1 form or 2 in your program – different staff providing the service = different form.
- v) Error cited by Kiki on verbal/telephone order – the citation was not about the order, rather that the order had not been signed later by the prescriber. There is not a specific date in the regulation for when these needs to be completed – within a reasonable timeframe, depends on the frequency of planned visits. Discussion about maintaining a good relationship with prescribers – we ask them for a lot of paperwork/signatures, some of which their time is not compensated – be thoughtful and manage the process/requests accordingly.
- vi) An example of a different med certificate form was presented by both Kiki and Cheryl – discussion ensued – outcome: use the official State med certificate form. There are two versions – both are acceptable – one doesn't have the reminder to put in the date range of the certificate – that info needs to be entered by the authorizing NT.
- vii) QAs – semi-annual frequency – discussion ensued. The expectation is that 6 months to the day is the timeframe within which QAs need to occur. There was a question raised about the FAQs offering date ranges – the cited reference is within the historical part of the FAQ and cannot be currently applied to practice.
- viii) Is it acceptable to not fill PRN orders until they are needed? After discussion consensus – if you have an order, you need a supply and a med log. The supply on hand for PRNs could be limited to a 3 day supply (ex. a trial/travel size bottle)
- ix) BHF is not seeing any particular He-M 1201 trends for deficiencies.
- x) A question was sent in asking about using NUR 404 in He-M 525 settings – this is not within BHF's purview.
- e) A projection of HRST to demo sign in, Clinical Review, medical fragility toggle on About Me page as well as the comment box on the HSI form and other navigational steps of HRST system ended our meeting. A reminder – in order to be a Clinical Reviewer you have to have completed the online rater training followed by the Clinical Reviewer training AND the system has to recognize you as both. If you have an HRST account you can look at your profile to see what is toggled on or off

**Next Meeting will be April 19, 2016:** reminder that Compassionate Care will provide a lunch n learn at 11am

**Submitted by:**  
**Jennifer Boisvert, RN**  
**Secretary, DDNNH**



MINUTES

April 19, 2016

- 1) Meeting was called to order with 25 members in attendance
- 2) Review and approval of the March minutes as written
- 3) Officers Reports :
  - a) Treasurer's Report – accepted as written
- 4) Business Discussion
  - a) November's homework – DVD – subgroup to meet after today's meeting – script given out previously. Anyone interested in participating is welcome to stay and join in the discussion.
  - b) Hospice/1201a –
    - i) There was a range of experiences with hospice presented by members – from difficult to wonderful
    - ii) Take away messages – be sure to work on relationships that work together during this difficult time (between hospice and NT). The shorter the timeframe of hospice introduction to death of the individual, the more challenging it is to mesh our two systems of care. Consider having increased frequency of team meetings to help people express and be on the same page for goals of care/support.
    - iii) Be aware – certain infections/illnesses while receiving hospice services – hospitalizations are discouraged and may lead to disenrollment. Fairly seamless for this process and to be re-enrolled after discharge from hospital.
    - iv) When to initiate a hospice evaluation? The sooner the better. Hospice companies are happy to provide an evaluation for whether the individual is eligible for hospice services. Even if the initial evaluation shows that the individual is not yet eligible, you have some baseline information gathered.
    - v) a member reported that this was a very challenging process with an experienced home care provider – very emotional, the entire process was short – essentially a month. Another member spoke up saying that she too had just had a pretty difficult time in a residential setting – hospice was instructing staff to give pain med frequently, guardian was aware and in agreement, the amount and frequency of recommended medication administration was concerning to the overseeing NT. Another member spoke of having a couple of experiences years ago with another area agency and a very involved family – overall wonderful experience. This past year had experience for over a year – the hospice nurse came in Monday and Friday. NT provided education to hospice about what NT responsibilities included – overall positive experience. Another member had a couple of experiences with hospice with a few speed bumps. Hospice has come back to work with staff after the individual has passed – this has been beneficial. In another example – the individual receiving hospice was cared for by family caregiver in a 521 setting with some staff. The staff did not have access to the hospice kit (waiver from state) – family caregiver provided all hospice medication support. Very emotional experience for family/caregiver.
  - c) Nominations sought for open positions:
    - i) Vice President: Angele Smith was nominated and agreed to run.
    - ii) Secretary: Jennifer Boisvert was nominated and agreed to run.
    - iii) DDNA liaison: Debi Ellis-Nailor was nominated and agreed to run.

An email will be sent out to the group to seek any additional nominations. If there are no other members nominated, there will not be a need for an election. If there are other members nominated who agree to run, an electronic request to vote will be sent out for any members who know that they will not be present at May's meeting the prior week.

- d) DDNA conference report – Debi: preconference day on forensic – excellent speaker, learned a lot, for example: need to consider supplements that can cause bruising (eg ginger). He talked a lot about insurance company

talking with us, about education, used graphic slides and had audience try to figure out what had happened – audience was usually wrong, recommended using body picture in incident report to document.

- i) Luanne attended the boot camp – very helpful info, syndrome sheets (Debi says these are much easier to study for CDDN instead of all the books she used), website recommended
- ii) Nanette spoke at the conference – take away message – psychotropic and allergy meds can be a poor mix (some allergy meds form a coat over the psych med – so the prescriber thinks it's not working and increases, when really the underlying issue is the body can't access the medication that is present)
  - (1) A brief discussion of available genetic testing considerations...Ellen shared that she has found 23 and me to be useful (<https://www.23andme.com/>)
  - (2) Pam commented about needing to be aware that clozaril use can result in very increased blood sugars (over 900) – person went into hospital, has permanent kidney damage. This individual also has Diabetes insipidus and uses lithium (which could be contributing factors).
- iii) Eileen – Dan Sheridan (forensic nursing speaker at pre-conference day) – says “cuts, scrapes and stuff” are preferential words. Rick Rader was the keynote speaker and compared our type of nursing with burn victims in WW2. Barb Bancroft's presentation was funny as usual and informative.
- iv) There were approximately 200 attendees at the conference. The venue was beautiful, everyone felt the environment and staff were welcoming. Overall DDNA membership has declined. There are now less than 400 CDDNs. Next year's conference is in Dallas, TX. Those in attendance were asked to help figure out ways to grow the organization.
- e) Compassionate Care presentation on Hospice with Jennifer Mahoney and several staff – thank you for the food and information!
  - i) After group introductions, Jennifer asked if there were particular areas of interest to cover – responses: alzheimers – (Answer – late stage is covered – individual who speaks 6 words or less now); disenrollment, how to develop relationship (eg what does hospice need from us).
  - ii) Hospice looks at decline of the past 6 months to a year – has 2 physicians certify need (PCP and hospice MD)
  - iii) Initial benefit period – 90 days, hospice team meeting, 2<sup>nd</sup> 90 day benefit, then APRN goes out for face to face visit – presents at hospice team meeting to determine if services can be continued.
  - iv) Compassionate Care doesn't have a bridge program, they do have weekly liaison monitoring to see if individual is declining and enroll in hospice when eligible.
  - v) Namenda and Aricept are not covered under Medicare in hospice.
  - vi) Aggressive treatment meds are generally not covered during hospice care – there may be initial consideration if the person or family needs a little time to adjust from treatment to hospice.
  - vii) Dialysis is considered aggressive treatment and not appropriate for hospice.
  - viii) Major differences between Compassionate Care and other hospice companies:
    - (1) can admit over the w/e
    - (2) nurses go out at least 2x/week – increases as needed. RN is on call 24/7
    - (3) aides – 5 days a week (Monday – Friday) for each patient for at least an hour (to provide 1:1 as respite) – can be up to 3 hours if needed.
    - (4) Only hospice in the state that has a veteran liaison (non medical) – coordinates veteran ceremonies (celebration), looks at veteran benefits eligibility, is someone who understands the veteran mindset
    - (5) Compassionate Care offers Reiki therapy, aromatherapy, essential oils and dog therapy.

#### **Next Meeting will be**

**Submitted by:**  
**Jennifer Boisvert, RN**  
**Secretary, DDNNH**